

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Peak Integrated
Healthcare

Respondent Name

Zurich American Insurance Co

MFDR Tracking Number

M4-23-0034-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

September 1, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 17, 2021	99204	\$298.41	\$0.00
September 17, 2021	99080-73	\$0.00	\$0.00
October 13, 2021	99213	\$0.00	\$0.00
October 13, 2021	99080-73	\$15.00	\$15.00
October 28, 2021	99213	\$7.03	\$7.03
October 28, 2021	99080-73	\$0.00	\$0.00
December 13, 2021	97110-GP	\$75.30	\$12.56
December 13, 2021	97112-GP	\$125.42	\$94.67
Total		\$521.16	\$129.26

Requestor's Position

The requestor did not submit a position statement with this request for MFDR only copies of their request for reconsideration.

Amount in Dispute: \$521.16

Respondent's Position

The Austin carrier representative for Zurich American Insurance Co is Flahive, Ogden and L2atson. The representative was notified of this medical fee dispute on September 7, 2022.

Per 28 Texas Administrative Code §133.307(d)(1), if the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its decision on the available information.

As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available.

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.203 sets out the fee guidelines for professional services.
3. 28 TAC §129.5 sets out the payment guidelines for work status reports.

Denial Reasons

The insurance carrier reduced or denied the disputed service(s) with the following claim adjustment codes.

- 99204 – 150 – Payment adjusted because the payer deems the information submitted does not support the level of service
- 99080 – 190 – billing for report and/or record review exceeds reasonableness
- 99213 – AP12 – The charge for this procedure exceeds the fee schedule allowance
- 97110, 97112 – 119 – Benefit maximum for this time period or occurrence has been reached
- 97112 – B12 – Services not documented in patient's medical record
- 163 – The charge for this procedure exceeds the unit value and/or the multiple procedure rules

Issues

1. Is the insurance carrier's denial supported?
2. Is the insurance carrier's reduction supported??
3. Is the requestor entitled to additional payment?

Findings

1. The requestor is seeking reimbursement of code 99204 – Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter for date of service September 17, 2021. The insurance carrier denied the disputed code as level of service not supported.

DWC Rule §134.203 (5) states, "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare.

Review of the submitted documentation found the total time is not documented. The documentation supports a low level of medical decision making. The coding requirements of the Medicare payment policy is not met. The insurance carrier's denial is supported.

The requestor seeks reimbursement of a work status report for date of service October 13, 2021. The insurance carrier denied the charge billing exceeds reasonableness.

DWC Rule §129, 5 states in pertinent part, Doctors, delegated physician assistants, or delegated advanced practice registered nurses billing for Work Status Reports as permitted by this section shall do so as follows: (1) CPT code "99080" with modifier "73" shall be used when the doctor, delegated physician assistant, or delegated advanced practice registered nurse is billing for a report required under subsections ©(1), ©(2), and (g) of this section;

Insufficient evidence was found to support the disputed service was in excess of fee guideline. The fee guideline amount is \$15.00. This amount is recommended.

The requestor is seeking additional reimbursement of code 99213 for date of service October 28, 2021. The insurance carrier reduced the allowed amount based on worker's compensation fee schedule.

DWC Rule §134.203(c) (1) states in pertinent part, to determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is conversion factor for disputed date of service.

The maximum allowable reimbursement is calculated as DWC Conversion Factor/Medicare

Conversion Factor multiplied by physician fee schedule allowable for specific location or;

$$(61.17/34.8931) \times 93.06 \text{ (Dallas)} = \$163.14.$$

The insurance company paid \$156.11. The requestor is seeking \$7.03. This amount is recommended.

2. The requestor is seeking additional payment of code 97110 – Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility, for date of service December 13, 2021 and full payment of code 97112 – Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities for date of service December 13, 2021.

The insurance carrier reduced the payment for code 97110 based on benefit maximum. The insurance carrier did not submit sufficient evidence to support services exceeded the Medicare payment policy. Code 97112 was denied as not documented. Review of the submitted documentation found the health care provider indicated under “Neuro-Lower Extremity” a total of 30 minutes or two units. The submitted medical bill was for two units. The insurance carrier’s denial is not supported. The physical therapy codes in dispute will be reviewed per applicable fee guideline.

The applicable DWC fee guideline for physical therapy is 28 TAC §134.203 (b) (1) which requires the application of Medicare payment policies applicable to professional services. The insurance carrier’s reduction of payment is supported.

The Medicare multiple procedure payment reduction (MPPR) applies to the Practice Expense (PE) of certain time-based physical therapy codes when more than one unit or procedure is provided to the same patient on the same day.

The MPPR policy allows for full payment for the unit or procedure with the highest Practice Expense (PE) payment factor and for subsequent units the Practice Expense (PE) payment factor is reduced by 50 percent.

Review of the submitted medical bill provided indicates that two procedures were billed by the health care provider. To determine the MPPR allowable, the services provided are ranked by their PE expense shown below.

Code	Practice Expense	Allowed Amount	Medicare Policy
97110	0.4	30.76/23.60	No MPPR 1 st unit MPPR applies additional units
97112	0.49	35.77/27.00	MPPR applies

The *MPPR Rate File* that contains the payments for 2021 services is found at

<https://www.cms.gov/Medicare/Billing/TherapyServices/index.html>.

- MPPR rates are published by carrier and locality.
- The services were provided in Dallas, Texas.
- The carrier code for Texas is 4412 and the locality code for Dallas is 11.

The following formula represents the calculation of the DWC MAR at §134.203 ©(1) & (2).

$$(\text{DWC Conversion Factor} \div \text{Medicare Conversion Factor}) \times \text{Medicare Payment} = \text{MAR}$$

Applicable 28 TAC 134.203(h) states that the total reimbursement is the lesser of the maximum allowable reimbursement (MAR) and the billed amount.

Date of Service	Code	Units	Medicare Payment	DWC Conversion Factor divided by Medicare Conversion Factor or 61.17/34.8931 = 1.75	Billed Amount	Lesser of MAR and billed amount
December 13, 2021	97110	6	\$30.76 \$23.60	\$53.92 \$206.86	\$323.52	\$260.78
December 13, 2021	97112	2	\$27.00	\$94.67	\$125.42	\$94.67
					Total	\$355.45

The total MAR is \$355,45, The insurance carrier paid \$248.22. An additional payment of \$107.23 is due to the requestor.

3. The total allowable for the services in dispute is \$533.59 the amount paid was \$404.33. A balance of \$129.26 is due to the requestor.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to additional reimbursement for the disputed services. It is ordered that respondent must remit to requestor \$129.26 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

January 6, 2023

Date

Signature

Medical Fee Dispute Resolution Officer

Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electrónico CompConnection@tdi.texas.gov.